East West
Massage & Therapeutics

Ayurvedic Intake Form

CONTACT INFORMATION

Name: Phone:

Address: City: ST: Zip:

Email: Occupation:

Sex: Height: Weight: Single: Coupled:

Date of Birth: Time of Birth City of Birth:

State of Birth: Country of Birth:

Emergency Contact

Name: Phone:

POLICIES & DISCLAIMER

There is a $36 service charge for all bounced checks. There is a $75 fee for missed appointments and for canceling less than 24 hours before your appointment.

This session is designed to inform you about the Ayurvedic viewpoint of various health concerns. It is in no way intended to diagnose or to prescribe treatment for any health problem. In the United States only a doctor can legally diagnose and prescribe treatment for disease. It is recommended that you discuss any Ayurvedic treatment method with your doctor before applying the treatment to yourself.

I have read and understand the above conditions:

Signature Date

CURRENT SYMPTOMS — DOSHA ASSESSMENT

VATA

- [ ] Dryness
- [ ] Insomnia
- [ ] Gas
- [ ] Bloating
- [ ] Constipation
- [ ] Hemorrhoids
- [ ] Muscle: Twitching, cramping
- [ ] Muscle: Numbness
- [ ] Weakness
- [ ] Joint Pain, Cracking
- [ ] Stiffness
- [ ] Shifting, tearing pain
- [ ] Dry Cough
- [ ] Cold Extremities
- [ ] Dry Skin
- [ ] Restlessness / Worry, Fear, Anxiety

PITTA

- [ ] Diarrhea
- [ ] Loose Stool
- [ ] Nausea
- [ ] Migraines
- [ ] Vomiting
- [ ] Skin rashes, acne, hives, boils
- [ ] Bruising
- [ ] Excess Thirst
- [ ] Burning, sharp pain
- [ ] Spontaneous bleeding
- [ ] Tenderness to touch
- [ ] Excess body heat
- [ ] Interrupted sleep
- [ ] Anger, rage, envy
- [ ] Judgmental, critical

KAPHA

- [ ] Congestion
- [ ] Food or respiratory Allergies
- [ ] Edema
- [ ] Heaviness
- [ ] Dullness
- [ ] Dull, vague pain
- [ ] Cold Clammy hands
- [ ] Difficulty sweating
- [ ] Frequent urination
- [ ] Excess oily skin
- [ ] Excess sleep
- [ ] Depression, greed, attachment
- [ ] Mental Lethargy

CHIEF CONCERNS

Chief concerns including origin, duration and progress of the symptoms:

LOCATION HISTORY

Place you were living when symptoms started:

Place of childhood:

Other places lived:

CURRENT MEDICATIONS

Please list any medications you are currently taking and what they are for:

ILLNESS HISTORY

History of any serious illness:

FAMILY HISTORY

Family history, maternal:

Family history, paternal:

APPETITE & DIGESTION — CHECK ALL THAT APPLY

Variable Appetite

- [ ] Appetite changeable
- [ ] Appetite changes with travel or disruption of routine
- [ ] Sometimes can skip a meal without noticing
- [ ] Strong appetite usually but sometimes not
- [ ] Appetite good and sometimes weak
- [ ] Coating on tongue
- [ ] Energy comes and goes
- [ ] Tendencies for flatulence

Strong Appetite

- [ ] Appetite is always strong
- [ ] Need to eat three meals per day
- [ ] Cannot skip any meal
- [ ] Need to snack between meals
- [ ] Excess thirst
- [ ] Hypoglycemic tendencies
- [ ] Irritable if meal comes late
- [ ] Can eat heavy foods anytime of day
- [ ] Can eat large meals anytime of day
- [ ] Can digest anything
- [ ] Tendency to diarrhea
- [ ] Raw/undigested food in stool
- [ ] Can eat much and often and can't/don't gain weight

Dull Appetite

- [ ] Appetite is dull
- [ ] Digestion takes 5-6 hours per meal
- [ ] Can skip a meal easily
- [ ] Don't eat breakfast or other meals regularly
- [ ] Heavy foods are hard to digest
- [ ] Large meals are hard to digest
- [ ] Heaviness, dullness, lethargy after eating
- [ ] Tendency to weight gain
- [ ] Rarely snack

SLEEP

What time do you go to bed?

How long does it take to fall asleep?

Do you wake in the middle of the night? How often?

What time do you wake up?

Do you feel rested and energetic upon waking?

Do you nap during the day? How long?

EXERCISE

How much cardiovascular exercise each week? (walking, running, bicycling, swimming, etc.)

Do you do strength training such as weightlifting? How much and how often?

Do you do stretching or mind-body exercises such as yoga or Qigong? How much and how often?

Do you do breathing exercises or meditation? How much and how often?

BOWEL MOVEMENTS

How many bowel movements do you have daily/weekly? What time of day?

Do you feel relieved after a bowel movement, or does it feel incomplete?

Do your stools sink or float?

Is there an odor?

Does the stool stick to the toilet bowl?

Are your stools compact, smooth and well-formed, pieces with well-defined edges, loose, or watery?

Are your stools black, brown, tan, green, yellow, or reddish?

URINATION

How many times per day do you urinate?

Is your urine clear, light yellow, yellow, dark yellow/brown?

Does your urine have an odor?

SWEAT

How often do you sweat?

Does your sweat have an odor?

Does your sweat stain your clothes?

MENSTRUAL CYCLE

Age of onset:

Age of cessation:

Length of menstruation:

Days between cycles:

Is the flow light, normal or heavy?

Are there clots?

Is the blood light red, dark red, or any other color?

Please list any PMS symptoms (mood swings, irritability, fatigue, bloating, breast tenderness, food cravings):

SUBSTANCE USE

Smoking, Alcohol, Caffeine, Recreational Drugs

How much and how often?

HYDRATION

How much water do you drink each day?

Besides alcoholic and caffeinated beverages, what other fluids do you drink?

Do you consume electrolytes such as salt, sugar, and citrus in addition to meals?

DIET

How often do you sit in a calm environment and devote your full attention to your food while eating?

How often are you truly hungry before eating?

What is your energy level after eating?

Please list the typical foods that you eat in a day and typical times you consume them:

OPTIONAL LAB VALUES

The following is optional. Please provide it if convenient.

What is your blood pressure?

Total Cholesterol: HDL: LDL: Triglycerides:

What is your A1C?

ADDITIONAL NOTES

Please list any questions, concerns, or anything else you would like me to know regarding the consultation: